## I. PURPOSE:

This document will clarify the process to acquire personal care through the Early Periodic Screening Diagnosis and Treatment (EPSDT) program. EPSDT services are available to Medicaid/FAMIS Plus/Medallion enrollees under 21 years of age and fee for service FAMIS enrollees under the age of 19. Personal care may be provided exclusively through EPSDT to eligible persons who have demonstrated a medical need for personal care that is not covered under an existing Medicaid program for which the individual is enrolled.

## II. BACKGROUND/DISCUSSION:

The EPSDT service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment becomes more costly. Examination and treatment services are provided at no cost to the individual.

Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS, its prior authorization contractor or a DMAS-contracted managed care organization as medically necessary.

The EPSDT personal care services can serve individuals who meet the criteria for EPSDT personal care. Health conditions must cause the individual to be functionally limited in performing three or more activities of daily living (ADL). These categories are bathing, dressing, transferring, ambulation, eating, toileting, and continence. The individual's inability to perform activities of daily living cannot be exclusively due to age. The functional deficits resulting from normal attainment of developmental milestones are not subject to EPSDT treatment because these functional deficits are not due to a health or mental health condition.

### Potentially Inappropriate Referrals for EPSDT Personal Care

Some individuals with a diagnosis of mental retardation, developmental disabilities, or related conditions have active treatment needs that cannot be met by EPSDT Personal Care services. Personal care services may not be suitable to correct or ameliorate all needs. If other treatment needs are present there are community based services that may be suggested to treat the health or mental health condition of the individual with behavioral or other treatment needs.

Referral to appropriate community based care services through the Community Based Mental Retardation (MR) Waiver or the Individual and Family Developmental Disabilities (DD) Waiver

and community mental health rehabilitation services may be necessary to promote appropriate community based health care for each individual.

EPSDT personal care may not be authorized when the individual presents with needs that cannot be ameliorated by personal care services consisting of ADL supports. When needs are primarily behavioral in nature, the appropriate community resources should be used to promote appropriate treatment and interventions to correct or ameliorate the suspected health condition. Each request for EPSDT Personal Care services will be reviewed on an individualized basis by DMAS.

**EPSDT and Community Based Care Waivers**

Home and community based waivers are programs designed to serve a specific targeted population. If an individual is currently Medicaid eligible and is on a waiver wait list or is enrolled in a home and community based care waiver, EPSDT services may be accessed if the intended services are medically necessary to treat the health condition as diagnosed by the EPSDT screener.

If the individual has been screened for waiver services, DMAS may request a copy of the completed screening instrument. The screening instrument will provide additional medical information about the conditions requiring treatment. **The waiver screening tool does not substitute for the EPSDT screening documentation that defines the medical need for EPSDT treatment services.**

**Managed Care Organization Referrals for EPSDT Personal Care**

EPSDT Personal Care services are carved out from the services provided by a DMAS-contracted Managed Care Organization (MCO). If an individual who is enrolled with a MCO requires Personal Care services then the individual will be screened by their primary physician, the physician will complete the functional assessment/DMAS-7 form and forward to DMAS or its preauthorization contractor for review.

## III. DEFINITIONS:

**Agency-directed Personal Care Services** – Personal care services provided by an agency chosen by the individual. The agency handles all of the employment components for the individual such as hiring and firing of the personal care aide. The agency bills DMAS for services provided.

**Activities of Daily Living (ADL)** – The basic daily tasks of bathing, dressing, toileting, transferring, eating, bowel continence, and bladder continence necessary to maintain an individual's health and safety.

**Centers For Medicare & Medicaid Services (CMS)** – The federal agency that administers the Medicare, Medicaid, and State Child Health Insurance programs.

**Consumer-Directed Personal Care Services-** Personal care services provided by an aide chosen by the individual. The individual or individual's representative handles all of the employment components for the individual such as hiring and firing of the personal care aide with the assistance of a Service Facilitation Provider. DMAS or its contractor reimburses the personal care aide for services received.

**Dependency** – The need for hands-on assistance from someone else to perform a personal care task.

**Diagnostic and Treatment Services** – Other necessary health care, diagnostic services, treatment and other measures listed in the Federal Medicaid statute, to correct and ameliorate physical and mental illnesses and conditions discovered by the screening services. The state may determine the medical necessity of the service and subject the service to prior authorization for purposes of utilization review.

**The Virginia Department of Medical Assistance Services (DMAS)** – DMAS is the state Medicaid agency and is responsible for administering the EPSDT program.

**EPSDT** (**Early and Periodic Screening, Diagnostic, and Treatment)** – The EPSDT program is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at section 1905(a) of the Act be provided to an EPSDT individual even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

**EPSDT Screener** – DMAS enrolled Physician, Physician's Assistant, or Nurse Practitioner.

**EPSDT Screening** – EPSDT screening services contain the following five (5) elements:

- A comprehensive health and developmental history, including assessment of both physical and mental health and development;
- A comprehensive unclothed physical examination;
- Appropriate immunizations according to the ACIP (Advisory Committee on Immunization Practice) schedule;
- Laboratory tests, (including blood level assessment);
- Each encounter must be appropriate for age and risk factors, and health education,

including anticipatory guidance.

**The chart below indicates when a child should receive an EPSDT screening:**

| INFANCY | EARLY CHILDHOOD | LATE CHILDHOOD | ADOLESCENCE |
|---|---|---|---|
| 1 month<br>2 months<br>4 months<br>6 months<br>9 months<br>12 months | 15 months<br>18 months<br>2 years<br>3 years<br>4 years | 5 years<br>6 years<br>8 years<br>10 years | 12 years<br>14 years<br>16 years<br>18 years<br>20 years |

**FAMIS –** FAMIS is Virginia's program that helps families provide health insurance to their children. Health insurance is important to make sure that kids are able to get all the help they need to grow up healthy. FAMIS stands for Family Access to Medical Insurance Security. FAMIS is a separate federal program from Medicaid. In Virginia FAMIS recipients are not eligible for EPSDT treatment benefits when enrolled in a managed care organization.

**Fee for Service Medicaid** – Enrollees in areas without a managed care organization or who have primary insurance from a private carrier receive health benefits that are administered directly from DMAS. This benefit package uses the DMAS provider network to receive healthcare services. "FAMIS fee for service" enrollees are eligible for EPSDT benefits when there is no Managed Care Organization that is contracted to serve their geographic region.

**Inter-periodic screenings** – These are screenings that are provided outside of and in addition to the regular periodic screenings in the periodicity schedule above. For example, the primary care provider may choose to screen adolescents ages 11-20 in accordance with the AAP schedule rather than biannually as required by the current DMAS periodicity schedule. Any medical provider or a qualified health, developmental or educational professional who comes in contact with the child outside of the formal health care system may request that an inter-periodic screening be performed by the PCP or other screening provider.

**Medallion** – MEDALLION is Virginia's primary care case management (PCCM) managed care program administered by the Department of Medical Assistance Services (DMAS). Recipients in MEDALLION regions are required to select or be assigned to a primary care provider (PCP). The PCP receives a monthly management fee for their assigned recipients and is responsible for the coordination of all of the recipient's health care needs, including any necessary referrals.

**Personal Care Services** – Support services provided in the home and community settings necessary to maintain or improve an individual's current health status. Personal care services are defined as help with activities of daily living, monitoring of self-administered medications, and

the monitoring of health status and physical condition.

**Plan of Care (POC**) – The document used to record the individual's service needs.

**State Plan for Medical Assistance** – The set of benefits approved by the Commonwealth of Virginia and the Centers for Medicaid and Medicare Services.

## IV. PROVIDER PARTICIPATION REQUIREMENTS:

### Agency-Directed Personal Care

The provider of services must be a home health or personal care agency that has a current signed participation agreement with DMAS to provide personal care. The most current Elderly or Disabled with Consumer Direction (EDCD) Waiver provider manual describes the activities required of the EPSDT personal care services provider.

Personal care service providers may be related to an individual, but may not be the parents of children less than 18 years of age or the individual's spouse. Payment may not be made for services furnished by other family members unless there is objective written documentation as to why there are no other providers available to provide the care. Family members who provide personal assistance services must meet the same standards as providers who are unrelated to the individual and must be employed by an agency.

### Consumer-Directed Personal Care

A participating Consumer-Directed (CD) Service Facilitator (SF) is a facility, agency, person, partnership, corporation, or association that meets the standards and requirements set forth by DMAS and has a current, signed Participation Agreement with DMAS. The most current EDCD provider manual and Employee Management Manual describes the service monitoring activities that are required of EPSDT Service Facilitation providers.

Service facilitation agencies provide supportive services designed to assist eligible individuals with the hiring, training, supervising, and firing responsibilities of the personal care aides, who perform basic health-related services. Any provider contracting with Medicaid to provide services agrees to adhere to all of the policies and procedures as described in the most current EDCD Waiver Employment Management and EDCD provider manual.

The inability to obtain and retain personal care aides can be a serious threat to the safety and health of a individual. If an individual is consistently (over a 30-day period) unable to hire and retain the employment of a personal care aide, the CD Service Facilitator should talk to the individual about Agency Directed Personal Care services.

## *CD Personal Care Aide Requirements*

It is the individual's responsibility to hire, train, supervise, and, if necessary, fire the personal care aide. Each personal care aide hired by the individual must be evaluated by the individual to ensure compliance with the minimum qualifications as required by DMAS. Basic qualifications for personal care aides include:

- Being 18 years of age or older;
- Being able to read and write in English to the degree necessary to perform the tasks expected;
- Possessing basic math, reading, and writing skills;
- Having the required skills to perform care as specified in the individual's plan of care;
- Possessing a valid Social Security Number;
- Submitting to a criminal history record check and a child protective services central registry check for care aides that care for minor children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files. The personal care aide will not be compensated for services provided to the individual once the records check verifies the personal care aide has been convicted of any of the crimes that are described in § 32.1-162.9:1 or § 37.2-416 of the Code of Virginia. Personal care aides who have not been convicted of crimes will be reimbursed for care provided prior to the results of a criminal history record check;
- Willingness to attend or receive training at the individual's request;
- Understanding and agreeing to comply with the CD personal care services program requirements;
- Receive periodic tuberculosis (TB) screening;
- Personal care aides may be members of the individual's family, with the exception of parents or stepparents of a minor (under 18 years of age), or a individual's spouse. In addition, anyone who has legal guardianship for the individual shall also be prohibited from being a personal care aide under this program. A non-family live-in personal care aide may be the provider of Medicaid-funded CD personal care services for any individual; and
- Personal care aides who are providing direct care to individuals are prohibited from also directing that individual's CD services.

The individual should verify information on the application form prior to hiring a personal care aide. It is important that the qualifications are met by each personal care aide to ensure the individuals health and safety. These qualifications must be documented by the individual and maintained by the CD Service Facilitator for review by DMAS staff.

CD Service Facilitators are not responsible for finding personal care aides for the individual. CD Service Facilitators are also not responsible for verifying personal care aides' qualifications. This is the individual's responsibility.

If a facility, agency, person, partnership, corporation, or association that meets the standards and requirements set forth by DMAS wishes to participate as a DMAS Personal Care provider, they should contact Provider Enrollment at:

First Health - Provider Enrollment Unit
P.O. Box 26803
Richmond, Virginia 23261-6803

Helpdesk Telephone Numbers:
(804) 270-5105 local (Richmond Area)
(888)-829-5373 toll free

## V. ELIGIBILITY CRITERIA:

To be eligible for EPSDT personal care services you must be a currently enrolled Medicaid or FAMIS Plus/Medallion recipient under the age of 21 years or a FAMIS Fee for Service enrollee under the age of 19. EPSDT personal care services can be provided to those individuals who meet medical necessity criteria for personal care services. DMAS, or its designee, is responsible for determining medical necessity. Individuals who may be eligible for a home and community based waiver will be referred to that program to be screened. In addition to medical necessity, the following criteria must be met in order for personal care services to be determined appropriate:

- The individual must be under the age of 21 and be enrolled in Medicaid/FAMIS Plus/Medallion or under the age of 19 and enrolled in FAMIS Fee for Service.

- The individual must have a plan of care developed by a currently enrolled personal care provider or services facilitator employed by the agency that will provide personal care or services facilitation in consultation with the individual. The plan of care (DMAS-7A) should be consistent with the findings on the EPSDT functional assessment (DMAS-7) and demonstrate the need for personal care.

- The individual must have a realistic and viable back-up plan, such as a family member, neighbor, or friend who is willing and able to assist the individual on very short notice in case the personal care aide does not show up for work as expected. This backup plan must be in writing and must be part of the individual's case record at the agency providing care or maintained by the service facilitation provider. The personal care or services facilitation provider is not responsible for providing back-up assistance. The

provider is not responsible for contacting the person identified on the back-up plan; this is the responsibility of the individual/family. Individuals who do not have a back-up plan are not eligible for services until a viable, written backup plan is identified and included in the individual's record.

**Medical Necessity**

Health conditions must cause the individual to be functionally limited in performing three or more activities of daily living (ADL). These categories are bathing, dressing, transfers, ambulation, eating/feeding, toileting, and continence. The individual's inability to perform an ADL cannot be exclusively due to typical limitations associated with typical attainment of developmental milestones. Individuals receiving EPSDT personal care must have a physician referral due to health conditions documented during an EPSDT medical exam. The service hours approved by DMAS will be based on medical necessity as defined in the providers' plan of care.

**The EPSDT Functional Status Assessment (Attachment A) must be completed by an EPSDT screener. An EPSDT screener is a nurse practitioner, physician's assistant, or a physician. A printable EPSDT Functional Status Assessment can also be obtained using the link for search forms on the DMAS website at www.dmas.virginia.gov and entering *DMAS-7* in the Number/Name box.**

## VI. COVERED SERVICES AND LIMITATIONS:

**The Following Services Are Covered:**

1. Assistance with activities of daily living (ADLs): bathing, dressing, toileting, transferring, eating/feeding, ambulation and bowel and bladder continence.
2. Assistance with meal preparation for the individual.
3. Medically Necessary Supervision related to a health condition.

**The Following Services Are *Not* Covered:**

1. General Supervision
2. Respite
3. Performance of tasks for the sole purpose of assisting with the completion of job requirements.
4. Assistance provided in hospitals, other institutions, assisted living facilities, and licensed group homes.

The unit of service for personal care services is one hour. Payment is available only for allowable activities that are pre-authorized and provided by a qualified provider in accordance with an approved Plan of Care (POC) and EPSDT program criteria.

EPSDT personal care services are limited to the hours and ADL support services specified in the DMAS 7A and the 99 A/B. The pre authorization is based on the hours of need documented in the assessment of need (99 a/b) and plan of care (7A). Each EPSDT care plan must be completed by either a Registered Nurse or CD Services Facilitator.

## VII. SERVICE INITIATION AND REFERRAL PROCESS:

The individual/guardian or case manager with consent from the individual/guardian may request that an EPSDT screener (physician, physician's assistant or nurse practitioner) complete the EPSDT Functional Assessment Form (DMAS-7). The DMAS-7 can be completed by receiving an inter-periodic screening through their primary care physician. The physician will forward the completed DMAS-7 to DMAS. If appropriate, DMAS will approve an EPSDT referral to a Consumer Directed Services Facilitator or a personal care agency and send (as needed) a provider list to assess care needs and develop a plan of care. The care plan and assessment are sent to DMAS for final preauthorization of EPSDT personal care services.

### Managed Care Organization (MCO) Enrollees

MCO enrollees or their guardian will initiate personal care services by a referral from their EPSDT screening providers to DMAS for approval of personal care services. **The MCO is not required to cover personal care services for Medicaid/FAMIS Plus enrollees.** MCO enrolled individuals will access personal care services by having an EPSDT screener (physician, physician's assistant or nurse practitioner) complete the DMAS-7. The DMAS-7 can be completed by receiving an inter-periodic screening through their primary care physician. The MCO will refer inquiries for Personal Care to DMAS for service authorization. DMAS or the individual's community based case manager for the individual will coordinate referrals to DMAS enrolled providers of personal care services.

### EPSDT Personal Care Referral and Service Initiation Process (All Enrollees)

Individuals may receive personal care through an agency-directed or consumer-directed model of care. The model of care is chosen by the individual or the caregiver if the individual is not able to make a choice. This choice must be made freely without interference from the provider or CD Service Facilitator.

1. The screener (as defined earlier) will conduct an assessment for EPSDT personal care using the (DMAS-7) functional assessment. (The screener may bill for an inter-periodic screening if the screening is in excess of the periodicity schedule)
2. The individual/case manager will send the completed DMAS-7 to DMAS.
3. DMAS will review the request to determine the appropriate services to meet the

individual's needs, if appropriate authorize a referral and send a provider list to the individual or community based case manager.

4. DMAS will refer the individual to his/her current community based case manager for care coordination or refer the individual directly to the existing community services options as appropriate.
5. The individual will select a personal care agency or Consumer Directed Services Facilitator and work with them and the case manager (if applicable) or Personal Care Agency to develop a plan of care using the DMAS 7-A.
6. The DMAS 7-A and evaluation will be sent to DMAS for pre authorization.
7. If authorized and no nursing needs are present, services may begin for up to one year (or as scheduled in the DMAS 7) upon issue of a pre authorization number.
8. If authorized and there is a suspected nursing need, a 60 day authorization of EPSDT services will be accompanied with a referral to the appropriate waiver screening team upon issue of a pre authorization number. The individual may receive nursing services through EPSDT if this service is not available through a waiver or state plan service.

Upon receipt of a completed DMAS-7 and before the delivery of services, the Consumer Directed Services Facilitator or Personal Care Agency must conduct an assessment. If the CD Service Facilitator is not a registered nurse, the CD Service Facilitator must inform the individual's primary health care provider that EPSDT treatment services are being assessed and request physician consultation as needed.

Accurate and complete authorization requests help reduce delays in authorization and service initiation. To ensure timely authorization for services, enrollments and all requests for service authorization must be submitted to the EPSDT Preauthorization Coordinator prior to initiation of EPSDT services. Providers will not be reimbursed for services rendered before the service is prior authorized by DMAS. Services may be authorized no earlier than the date that the EPSDT Preauthorization Coordinator receives all requested information. Providers wishing to start services prior to the receipt of authorization do so with the knowledge that they are taking a risk of not receiving reimbursement for services provided. The provider must have a Medicaid identification number for any authorized individual prior to the start of Medicaid-funded services if the provider wants to be guaranteed payment for services provided.

**DEVELOPMENT OF THE PLAN OF CARE (DMAS-7-A):**
**EPSDT AGENCY AND CONSUMER-DIRECTED PLANS OF CARE**

The DMAS-7-A must be completed by the provider's RN or Consumer Directed Services Facilitator prior to the start of care for any individual. The EPSDT Functional Assessment form (DMAS-7) indicates to the provider the personal care needs of the individual. The provider/CDSF must indicate the time required to provide the necessary supports as documented in the DMAS 7. Time needs to be allocated for each task on the plan of care. Each sub-category

must be totaled if time has been allotted to that category.

Each individual receives hours of care based on the total time required to complete all personal care support activities as documented in the DMAS-7 functional assessment. The EPSDT Personal Care support categories are bathing, dressing, transfers, ambulation, eating and toileting. The time needed to provide IADL and special supervision supports are included in the total care hours authorized when the supports needed are due to a diagnosed health condition.

**Personal Care Split-Shift Service Delivery (Agency and Consumer-Directed)**

There are situations in which the individual may benefit from services offered during two distinct shifts during the day (i.e., morning and evening). The provider must complete two plans of care, labeled morning or afternoon, to indicate each shift of services. The total number of hours on morning and afternoon plans of care combined cannot exceed the number allowed for the individual's level of care without prior approval from DMAS.

**Changes to the Plan of Care**

The provider is responsible for making modifications to the plan of care as needed to ensure that the aide and individual (or family) is aware of the tasks to be performed and that the hours and type of care are appropriate to meet the current needs of the individual.

Any time the number of hours, for a individual, need to be changed, the provider must develop a new plan of care and submit to DMAS. The most recent plan of care must always be in the individual's home. These plans of care and documentation of service delivery must be consistent with the information submitted to DMAS or designee. Changes in coverage must be submitted to DMAS using the DMAS-351 and a new plan of care reflecting the revised hours. Providers are required to submit changes in hours of care five business days before they occur. Always use the DMAS Request for Services Form (DMAS-351) when submitting any request.

## VIII. PRIOR AUTHORIZATION REQUIREMENTS:

The provider will complete the evaluation and POC, and forward them to DMAS. DMAS will coordinate a review of the POC with the DMAS Medical Support Unit to assess the level of need and determine if the service amount meets EPSDT criteria for reimbursement. DMAS has 10 business days to review each service request. If the service is approved, a prior authorization notice will be sent to the provider and the individual to inform them that services meet EPSDT personal care medical necessity. The notice will include the preauthorization number issued through the Medicaid Management and Information System. This number is the provider's authorization to bill for services rendered.

**Requests for services may be faxed to: (804) 786-5799.**

**Requests for services may be mailed to:**

EPSDT Coordinator
Maternal and Child Health Division/11th Floor
600 E. Broad St., Ste 1300
Richmond VA, 23219

**Provider Requests should contain the following:**

- 7-A from provider
- 99A/B Community Based Care Recipient Assessment Report
- Back-up plan documented
- Detailed schedule of current services available to individual
- Universal Assessment Instrument (UAI) from Personal Assistance Screening (PAS) team: if completed for waiver denials
- Level of Functioning (LOF) for all MR and DD waiver waitlist approved individuals

## IX. DOCUMENTATION REQUIREMENTS:

The most current EDCD Waiver provider manual and employee Management Manual describe the service monitoring activities that are required of EPSDT Personal Care and EPSDT Service Facilitation providers. The documentation requirements are identical with the exception that the 97 A/B form is equal to the 7A form.

## X. REIMBURSEMENT:

EPSDT Personal Care Providers are reimbursed at the current payment rate used by the Home and Community Based Waivers.

**EXHIBITS:**

EPSDT Personal Care Services Forms Description

DMAS-7 Functional Assessment form Completed during an EPSDT screening or health encounter by a Physician or Nurse Practitioner. Used to medically justify EPSDT personal care services. This form is used by DMAS to allow a referral to a Personal Care agency or Service Facilitator.
DMAS-90 – Provider Aide Record (Personal & Respite Care)
DMAS-95B – Consumer Direction Services Management Questionnaire
DMAS-7A – EPSDT Provider Plan of Care
DMAS-351 – DMAS EPSDT Request for Services Form
DMAS-99 – Community Based Care Recipient Assessment Report
Consumer-Directed Recipient Comprehensive Training Form (Outline & Checklist)

**EPSDT PERSONAL CARE SERVICES FORMS DESCRIPTION SHEET**

You may download these forms from the DMAS website at www.dmas.virginia.gov.

1. DMAS-90 Provider Aide Record (Personal Care)
Used by the agency-directed personal care aide to document daily care tasks to the individual. This is used for agency-directed EPSDT personal care only. It is to be used along side of the Provider Agency Plan of Care (DMAS-97A/B). It must be filled out, dated, and signed by the aide who is providing the hands-on care. The individual or caregiver must sign it; if this is not possible, the reason must be documented in the individual's file. The completed form is kept in the individual's file at the provider agency. This is the only documentation that DMAS will use to verify that services were performed.

2. DMAS-95B Consumer Direction Services Management Questionnaire [Questions to consider if you want to manage consumer-directed (CD) services on behalf of an individual]. This form is a part of the CD Employee Management Manual. The service facilitator assists the family member who is considering managing the Plan of Care and being the employer on behalf of the Waiver individual in filling this form out. This form is only a tool to assist the family member and not to be used for authorization of services. The facilitator does not need to keep a copy on file.

3. DMAS-7A EPSDT Provider Plan of Care
Must be completed by the provider agency RN or Consumer Directed Services Facilitator prior to or on the day of the initial assessment visit for all individuals. The RN/ Consumer Directed Services Facilitator uses this to determine the level of care (amount of hours and type of services) that is appropriate for the individual. It will also have the effective date of services and the total number of hours of service per week. The RN/CDSF must review the Plan of Care with

the individual, family and/or caregiver, and the personal care aide/LPN. It will list the services that the aide/LPN is to provide for the individual. The RN will also complete this for an increase or decrease of hours. If the individual transfers to another personal care agency, the new provider will complete this form. A copy is to be kept in the individual's home and a copy included in the Pre-authorization packet for authorization of EPSDT services. The original is to be kept in the individual's file at the provider agency.

4. DMAS-351- Request for Services Form
The provider agency uses this form when requesting authorization or a change in the amount of services. The provider sends this to DMAS for Pre-authorization of EPSDT specialized services.

5. DMAS-99 Community Based Care Recipient Assessment Report
The DMAS-99B is now combined with this form. The RN Supervisor or Consumer Directed Services Facilitator must complete it prior to or on the day of the initial assessment visit for all individuals. The RN Supervisor/Consumer Directed Services Facilitator uses this to assess and document the individual's functioning status, to determine the individual's eligibility, any changes in medical condition, hospitalizations, medical/nursing needs, and support system. The RN Supervisor/Consumer Directed Services Facilitator must utilize this form on every routine visit. The RN Supervisor/ Consumer Directed Services Facilitator should read the instructions of this form to know which sections must be filled out on routine supervisory visits. The entire form must be completed on the initial assessment and during the six-month re-assessment. The form must be signed and dated by the RN Supervisor/Consumer Directed Services Facilitator conducting the supervisory visit and filed in the individual's record within five days of the visit. A copy of the initial assessment must be sent to DMAS for preauthorization of EPSDT services. All originals are to be kept in the individual's file in chronological order.

6. Consumer-Directed Recipient Comprehensive Training Form (Outline & Checklist)
The Consumer Directed Services Facilitator uses this when providing Management Training. It is an outline of the minimum subjects that DMAS requires the Consumer Directed Services Facilitator to cover during the training. The Consumer Directed Services Facilitator must check each subject on the form after it has been covered, and have all the required signatures and dates. This form must be maintained in the individual's files and be available for review by DMAS staff.

# EPSDT PERSONAL CARE PROGRAM

## AGENCY-DIRECTED & CONSUMER-DIRECTED PLAN OF CARE

*FAX ALL EPSDT SERVICE REQUESTS TO DMAS @ 804-786-5799*

☐ **AGENCY DIRECTED SERVICES (T1019)** ☐ **CONSUMER DIRECTED SERVICES (S5126)**

| | | | |
|---|---|---|---|
| Recipient Name: | | Medicaid ID#: | |
| Provider Agency: | | Provider ID#: | |

CHECK EACH TASK TO BE DONE, THEN ENTER THE TOTAL TIME FOR EACH DAILY CATEGORY

| Categories/Tasks | | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|---|
| **1.** | **ADL's** | | | | | | | |
| | Bathing | | | | | | | |
| | Dressing | | | | | | | |
| | Toileting | | | | | | | |
| | Transfer | | | | | | | |
| | Assist Eating/Feeding | | | | | | | |
| | Assist Ambulate | | | | | | | |
| | Continence-Bowel | | | | | | | |
| | Continence-Bladder | | | | | | | |
| | **ADL TIME:** | | | | | | | |
| **2.** | **Special Maintenance** | | | | | | | |
| | Vital Signs | | | | | | | |
| | Supervise Meds | | | | | | | |
| | Range of Motion | | | | | | | |
| | Wound Care | | | | | | | |
| | Bowel/Bladder Program | | | | | | | |
| | **Time:** | | | | | | | |
| **3.** | **Special Supervision Time** | | | | | | | |
| | **Supervision Reasons:** | | | | | | | |
| | Elopement/Wandering | | | | | | | |
| | Aggression/Self Harm | | | | | | | |
| | Impulsivity | | | | | | | |
| | Safety/Destructive | | | | | | | |
| **4.** | **IADLS** | | | | | | | |
| | Meal Preparation | | | | | | | |
| | Clean Kitchen | | | | | | | |
| | Make/Change Beds | | | | | | | |
| | Clean Areas Used by Recipient | | | | | | | |
| | Laundry | | | | | | | |
| | **IADLS Time:** | | | | | | | |
| | **Total Daily Time:** | | | | | | | |

**This Section Must Be Completed in its Entirety for Agency & Consumer-Directed Services**

Reason Plan of Care Submitted: ☐ New Admission ☐ ↑ In Hours ☐ ↓ In Hours ☐ Transfer

Reason for change/additional instructions for the aide/attendant: _____

_____

Backup Plan/Person (CD Services): _____

Plan of Care Effective Date: _____ Total Weekly Hours: _____

Enrollee Signature: _____ RN or SF Signature: _____

# Instructions for the DMAS-7A (29-Nov-07)

**Provider Notification To Client**

This Plan of Care has been revised based on your current needs and available support. If you agree with the changes, no action is required on your part. If you do not agree with the changes, you may contact the RN Supervisor or CD Services Facilitator who has signed the plan of care to discuss the reason you disagree with the change.

## Instructions for Completion of the DMAS-7A

**Care Determination For Determining Amount of Weekly Care Hours**
Enter the time necessary to complete each activity of daily living (ADL) based on the client's current functioning. Sum each ADL rating & enter the total time under **TOTAL DAILY TIME.**

**Provider Notification To Client**
Anytime the RN Supervisor or CD Services Facilitator (SF) changes the plan of care that results in a change in the total number of weekly hours, the RN or SF must complete the entire front section of this form. If the change the agency is making does not require DMAS approval, the RN Supervisor or SF is required to enter the effective date on the Provider Agency Client Notification Section and make sure the enrollee gets a copy of both the front and back of the form.

**If you have QUESTIONS about filling out this form please contact the Maternal and Child Health Division at (804) 786-6134.**

# EPSDT Personal Care Services
# Functional Status Assessment (DMAS-7)

**Complete when personal care is ordered**
**This form must be completed by a Physician, Physicians Assistant or Registered Nurse Practitioner**

| | |
|---|---|
| **Name:** | **Medicaid Number:** |
| **Date of Birth:** | **Primary Diagnosis:** |
| **Parent/Guardian's Name:** | **Phone #:** |

**Care needs must be related to a health condition and cannot be due to functional limitations associated with the normal attainment of developmental milestones**

**Indicate how the individual performs the following support needs:**

| ADLS/Mobility Supports | Needs Help | | Performed by Others | |
|---|---|---|---|---|
| | No | Yes | No | Yes |
| Bathing | | | | |
| Dressing | | | | |
| Toileting | | | | |
| Transferring | | | | |
| Eating/Feeding | | | | |
| Continence-bowel | | | | |
| Continence-bladder | | | | |
| Ambulation | | | | |

**Indicate how often the individual engages in the following activities:**

| Behavioral Supports | Harm Self or Others | Threaten or Act Aggressive | Attempt Elopement |
|---|---|---|---|
| Daily | | | |
| Weekly | | | |
| Monthly | | | |
| Every 3-4 months | | | |

| | |
|---|---|
| **Physician, Physicians Assistant or Nurse Practitioner Name (please print):** | |
| **MD/PA/RNP Signature/ Date:** | |
| **Provider ID #:** | |

**Fax completed form to: Maternal and Child Health Division /Fax – 804.786.5799**
**For questions about EPSDT email epsdt@dmas.virginia.gov**

**Receipt of personal care will depend on DMAS prior authorization based on EPSDT Personal Care Services Criteria.**